

Vermont Health Connect Update

January 13, 2014

Agenda

- 2015 Qualified Health Plan Process
 - 2015 Timeline
 - Review of 2012 decisions
 - 2014 Request for plan design changes
- Administrative Rule
 - Review of the development of the adopted rules
 - The next permanent rule
- Vermont Health Connect Data
 - Customer Support Center

Proposed 2015 Plan Design Adjustments

2015 Plans Timeline

- DVHA will recommend plan adjustments to GMCB January 16, 2014
- Carriers must file forms no later than March 1, 2014
 - Form review would conclude no later than May 31, 2014
- Carriers must submit rates on June 1, 2014
 - Rate review would conclude by August 31, 2014, (September 30, 2014 if necessary)
- VHC plan selection would begin September 1, 2014 and conclude no later than November 14, 2014
- Open enrollment from November 15, 2014 to January 15, 2015

2015 Plan Design Adjustment

- 2014 DVHA will request two adjustments to plan designs
 1. To provide zero cost sharing for Class I pediatric dental benefits
 - Class I are basic services: screenings, exams, x-rays, cleanings, routine fillings.
 - EXCEPTION: Deductible must be applied in plans which are Health Savings Account qualified, in order to keep their tax advantage.
 2. To reduce specialist office visits to \$50 on 1 standard bronze plan which each carrier offers. Two (2) plans in total.

- [Pending further analysis, on January 16, DVHA may also request a third set of adjustments to plan designs to maintain AV levels of standard plan designs.]

REVIEW: EHB & PLAN DESIGN

ACA Requirements: Essential Health Benefits

Must Include Services Within 10 Categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services, and chronic disease management
- Laboratory services
- Preventive and wellness services
- Pediatric services, including oral and vision care

2012 GMCB EHB Decisions

- EHB benchmark plan: BCBSVT
 - Mid range in cost
 - Comprehensive in services
 - Familiar to most
- Pediatric Dental: SCHIP benefit package
 - Identical to coverage under Medicaid and familiar to more Vermont families than federal benefits

Important plan design features

- **Actuarial value:** Percentage of an average enrollee's medical costs that an insurance provider is expected to cover
- **Cost-Sharing /out-of-pocket cost:** Charges for covered services billed to the subscriber: deductibles, copays, & co-insurance
- **Maximum out-of-pocket (MOOP):** Annual limit set by federal government that an enrollee pays out-of pocket for covered services; over the limit plan pays 100% for covered services
- **Deductible:** Amount an enrollee must pay before the plan pays for covered services. Waived for certain preventive services.
- **Copay:** Set dollar amount in a plan that an enrollee must pay as a share of the cost of a covered service
- **Co-insurance:** Percentage amount an enrollee must pay as a share

Definition of plan design

- The total cost of providing EHB will be split between insurance coverage (funded by premiums) and what enrollees pay out-of-pocket for covered services.

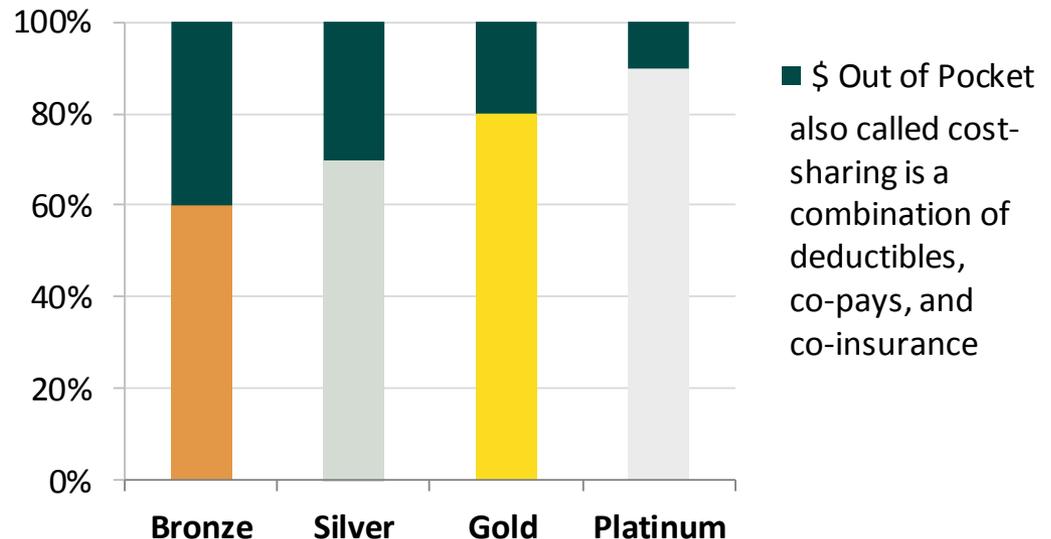
Qualified health plans are grouped into four sets of actuarial value (AV) or “metal level” which is the amount covered by insurance:

Bronze – 60%

Silver – 70%

Gold – 80%

Platinum – 90%



Factors Driving Plan Designs

- Additional federal regulations
 - Out of pocket maximum limits of \$6350 for single, \$12,700 for family (HHS proposed \$6750 /\$13,500 for 2015.)
- Vermont prescription drug law
 - Limits out of pocket expenditures for Rx to \$1250/\$2500 (may rise)

Principles for Decision Making

- Creating meaningful choice for consumers
- Encouraging high value services, like primary care and generic drugs, and innovation – in alignment with State priorities
- Minimizing disruption for small group and individual market
- Maximizing portability of plans, allowing consumers to move between employer and individual coverage while maintaining desired plan
- Affordability
- Administrative simplicity
- Maximizing individual premium tax credits

Hybrid Approach to Plan Designs

- A **hybrid approach** of state-specified plan designs and some “choice” plans designed by insurance carriers within set parameters
- **GMCB approved 6 specified design options across four actuarial levels:**
 - At Platinum: 1 Specified Plan Design
 - At Gold: 1 Specified Plan Design
 - At Silver: 2 Specified Plan Designs (1 can be paired with a health savings account (HSA))
 - At Bronze: 2 Specified Plan Designs (1 can be paired with an HSA)
- “Choice” Plan Designs proposed by carriers within criteria

Summary of Plans on VHC

- Twenty (20) total medical plans
- DVHA selected 6 standard plans from each carrier
 - At Platinum: 1 BCBS & 1 MVP
 - At Gold: 1 BCBS & 1 MVP
 - At Silver: 2 BCBS & 2 MVP (1 BCBS/1 MVP may be paired with HSA)
 - At Bronze: 2 BCBS & 2 MVP (1 BCBS/1 MVP may be paired with HSA)
- DVHA selected 3 carrier designed plans from each carrier (6)
- Federally mandated catastrophic plan
 - 1 BCBS and 1 MVP

Future revisions to approved plan designs

GMCB Approved: DVHA may make minor modifications to approved plan designs under the following conditions:

1. As needed to meet forthcoming federal guidance
2. Modifications restricted to the following:
 - Co-pay changes of *less than or equal to* \$15
 - Co-insurance changes of *less than or equal to* 5 percentage points
 - Deductible changes of *less than or equal to* \$200

2015 PROPOSED ADJUSTMENTS

2015 Plan Design Adjustments Request 1

- Zero cost sharing for Class I (basic) pediatric oral health essential health benefits
 - Deductible does not apply, zero co-insurance, and zero co-pay
 - Except on certain plans: Deductible would apply on plans which are Health Savings Account qualified under IRS regulations in order to keep their tax advantage status. However, zero co-pays and zero co-insurance for the Class I services after the deductible is met.

2015 Plan Design Adjustments Request 2

- To reduce specialist office visits from \$80 to \$50 on the standard deductible bronze plan (2 total plans).
 - *A deductible plan is distinct from an HSA qualified high deductible plan, also known as a HDHP or a CDHP.*
 - Responsive to concerns raised by consumer advocates, carriers, and certain specialty providers
 - To offset, raise maximum out-of-pocket limits from \$6350 to \$6750 for individual and \$12,700 to \$13,500 for non-individual plans.

2015 Plan Design Adjustments Request 3

- HHS has updated federal actuarial value calculators for 2015
 - Update plan designs as necessary to maintain metal levels as a result of new calculations under the proposed 2015 federal AV calculator

Health Benefits Eligibility and Enrollment Rules Update

TOPICS

- Review of the development of the rules that have been adopted
 - Rule adopted August 2013 (eff. October 1, 2013)
 - First emergency rule filed September 2013 (eff. October 1, 2013)
 - Second emergency rule filed December 2013 (eff. January 1, 2014)

- The next permanent rule

REVIEW OF ADOPTED AND EMERGENCY RULES

Eligibility and Enrollment Rules

- These rules govern health benefits eligibility and enrollment
 - Individuals' eligibility and enrollment for Medicaid, & for qualified health plans (QHPs) sold in the merged individual and small group insurance market
 - Individuals' eligibility for federal tax credits that help pay for QHP premiums and for subsidies reducing out-of-pocket costs
 - Individuals' eligibility for state subsidies that help pay for QHP premiums and reduce out-of-pocket costs
 - Small group eligibility and enrollment in QHPs

The August 2013 Rule

- Adopted under a formal process set out in the Administrative Procedures Act
 - Before the formal regulatory process began we held six informal public meetings (December 2012 through March 2013) to explain our progress, share drafts, and get feedback
 - Formal process included a notice of public hearing and formal comment period
 - Resulted in about five hundred comments

First emergency rule, September 2013

- Filed at the end of September 2013
- What emergency? Open enrollment, not enough time
- The federal government published numerous rules after we began the formal process for the July rule
- State legislature passed new laws that also had to get into the rule before open enrollment
- Comments from the July Rule we didn't get to in July
- Carriers and VLA submitted further comments

Second emergency rule, December 2013

- Federal government keeps on issuing new regulations
- Have had to rethink how enrollment is actually working
- Add clarifications
- More technical and substantive corrections
- Limited public engagement
- Respond to carriers and VLA comments

NEXT ROUND OF RULES

Another Emergency Rule

- More emergency rules? Yes. End of March 2014
- Emergency rules are effective for no more than 120 days, the second emergency rule ends at the end of April 2014
- Our formal rule process last year took from 4 to 7 months depending on how you look at it
- Our authority to file more emergency rules expires at the end of March 2014

Pre-filing the next permanent rule

- Will replace the 3rd emergency rule which would expire at the end of July
- Drafters informal meeting at 208 Hurricane Lane, 1/22/14, 9:30AM.
- Starting with the second emergency rule, <http://dcf.vermont.gov/sites/dcf/files/pdf/esd/rules/B13-46E.pdf>
- Rules pre-filed with ICAR (at least one week before ICAR's scheduled meeting on the 2nd Monday of the month)

Filing Proposed Rule

- File proposed rules with SOS at least 15 days following ICAR Pre-Filing
- Notice posted on SOS website on the Wednesday of the week following receipt
- Notice published in the “Newspapers of Record” (SOS publishes on the Thurs two weeks following receipt)
- Public hearing held no sooner than 30 days from when the rules are posted on SOS website
- Public written comment period deadline no sooner than seven days following public hearing
- Public comments and responses incorporated in the final proposed rules bulletin

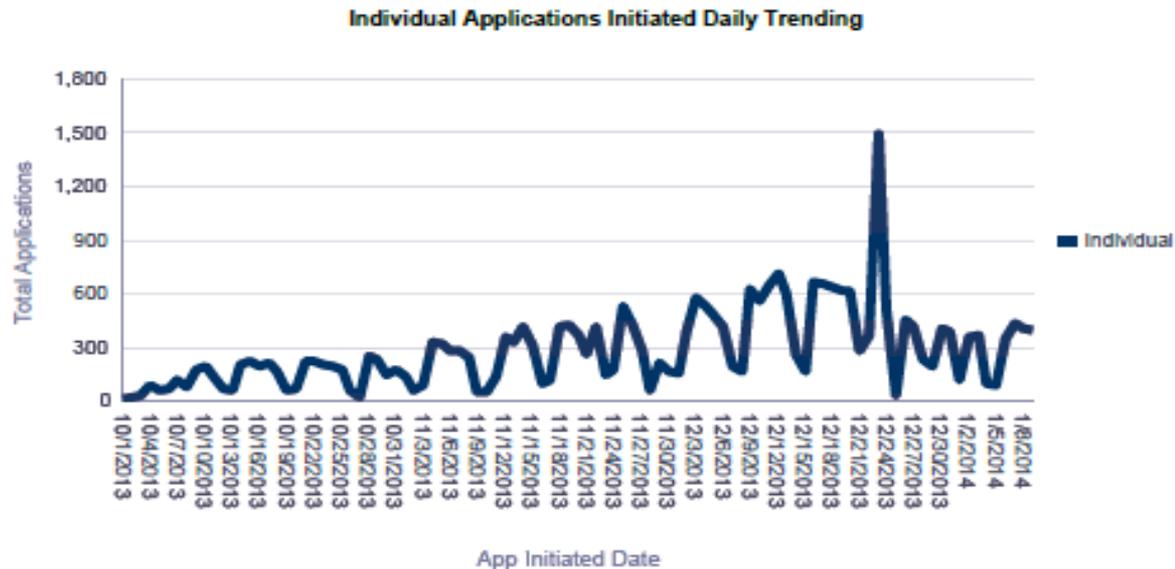
Filing Final Proposed Rule

- Final proposed rules filed with SOS and LCAR (at least 2-weeks before LCAR scheduled meeting)
- LCAR meets (weekly when in session and bi-monthly when out-of-session)
- File adopted rules with SOS
- Effective date: 15 Days following filing with SOS. The end.

Vermont Health Connect Data Update

Application Activity (*data as of 1/10/14*)

- Accounts Created: 35,079
- Applications submitted (QHP/Medicaid): 28,807
- Number of individuals (QHP/Medicaid): 39,722



Plan Confirmation - # of Individuals

- Individuals 25,030
- QHP: 15,108
 - BCBS: 13,317
 - MVP: 1,911
- Medicaid: 9,922 (5,532 new to Medicaid)
- Dental: 1,395

- Individuals with Effectuated Coverage: 6974

Eligibility- # of Individuals

- Eligible for QHP Financial Assistance: 12,381
 - APTC only: 19%
 - APTC & CSR: 80%

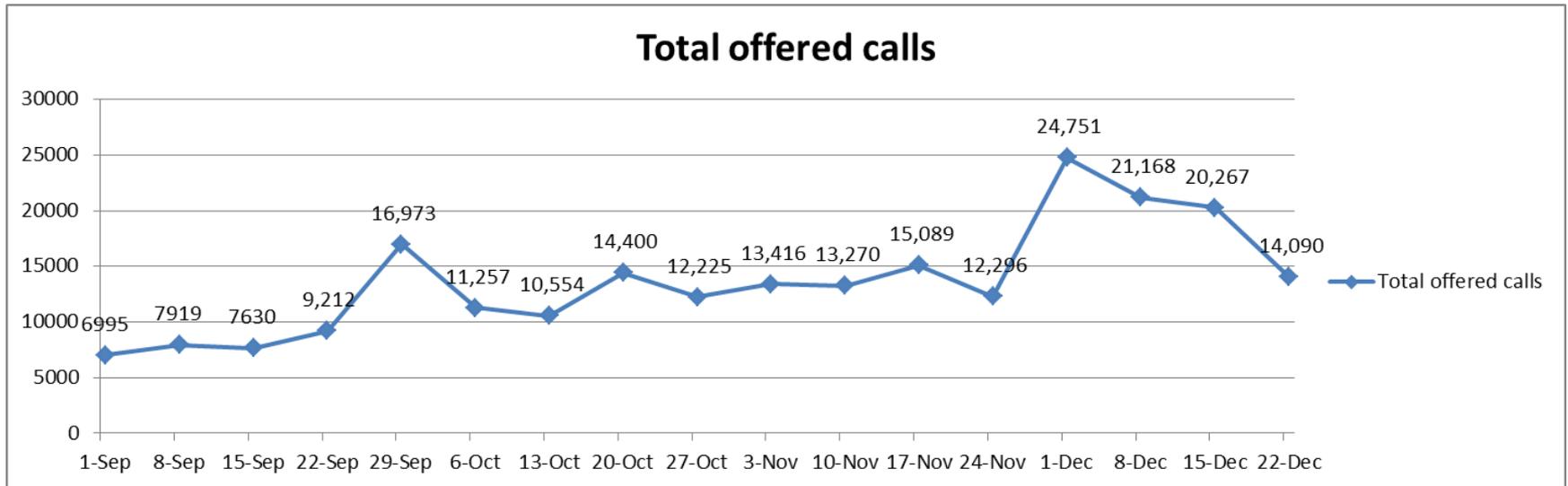
Assisted Applications

- Broker: 508
- Navigator: 3205

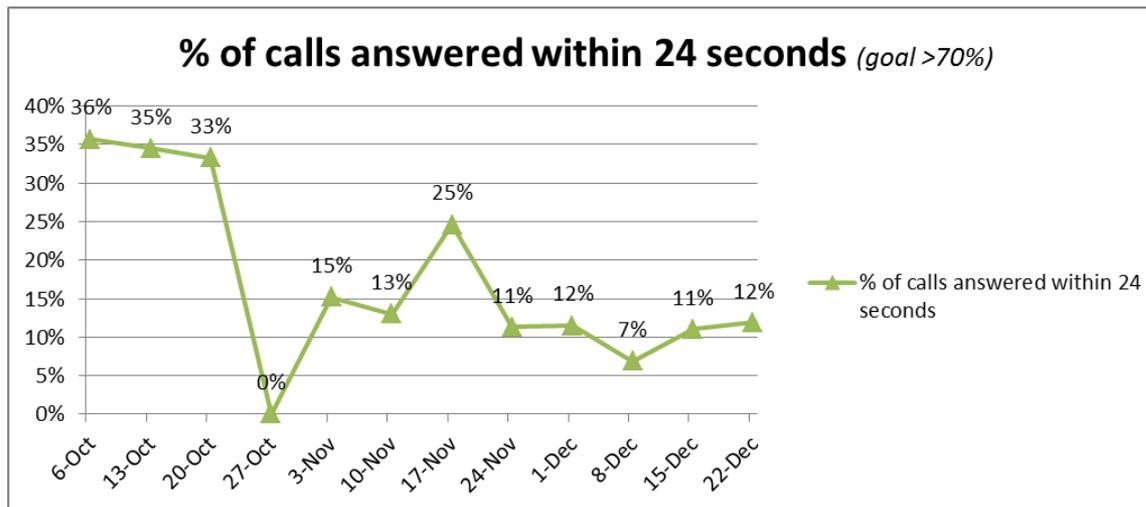
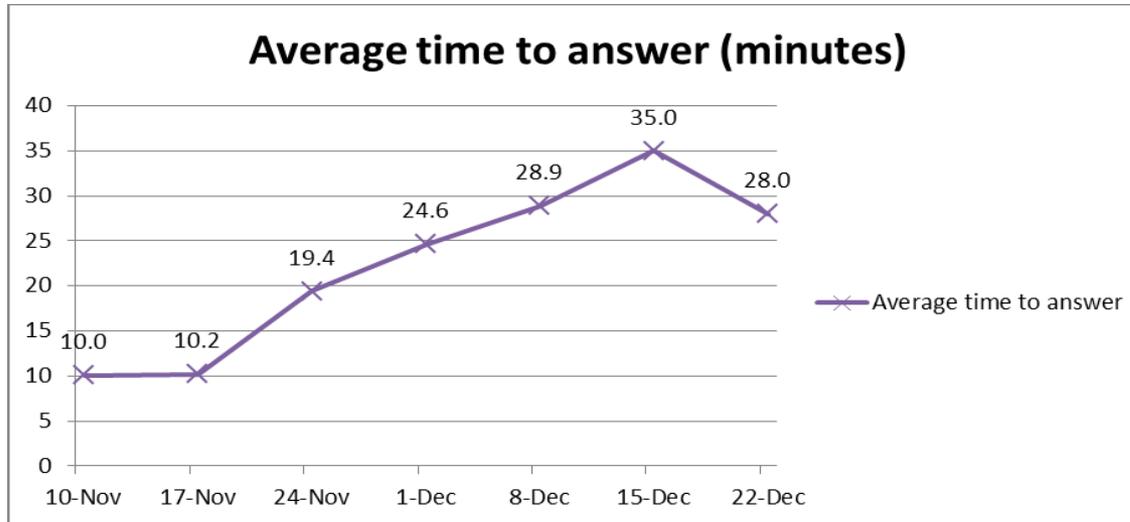
Vermont Health Connect Customer Service Center

October – December 2013

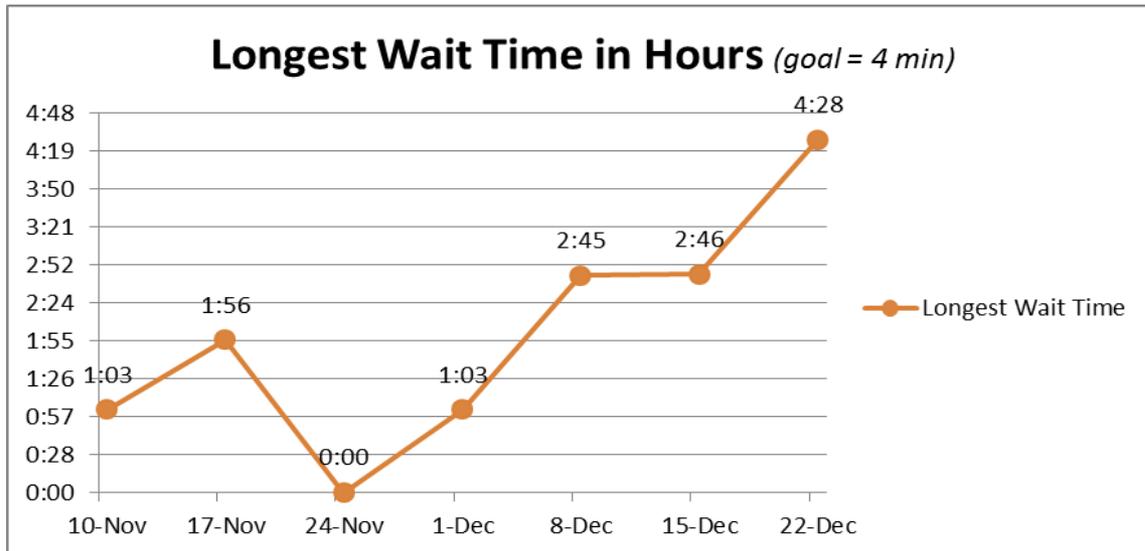
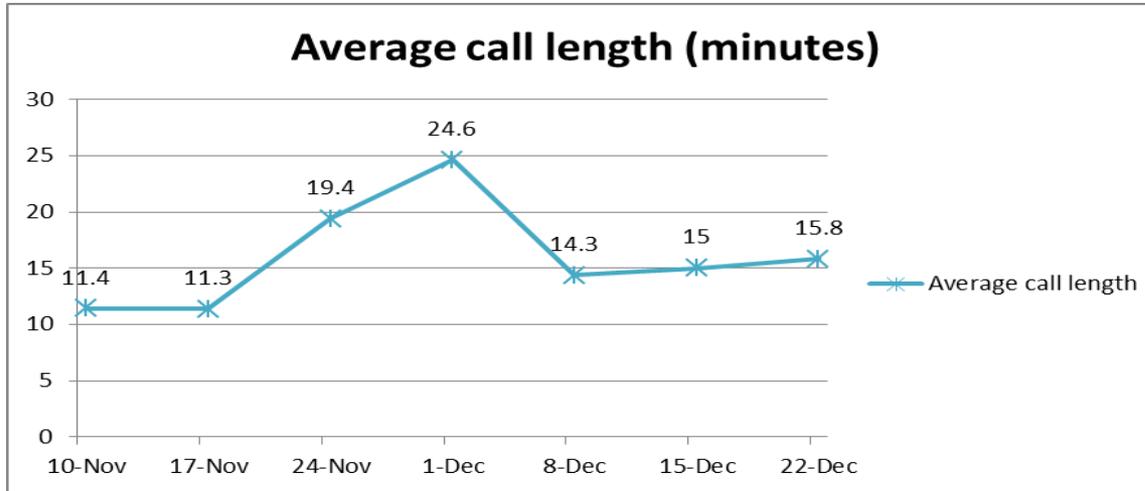
Incoming Call Volume



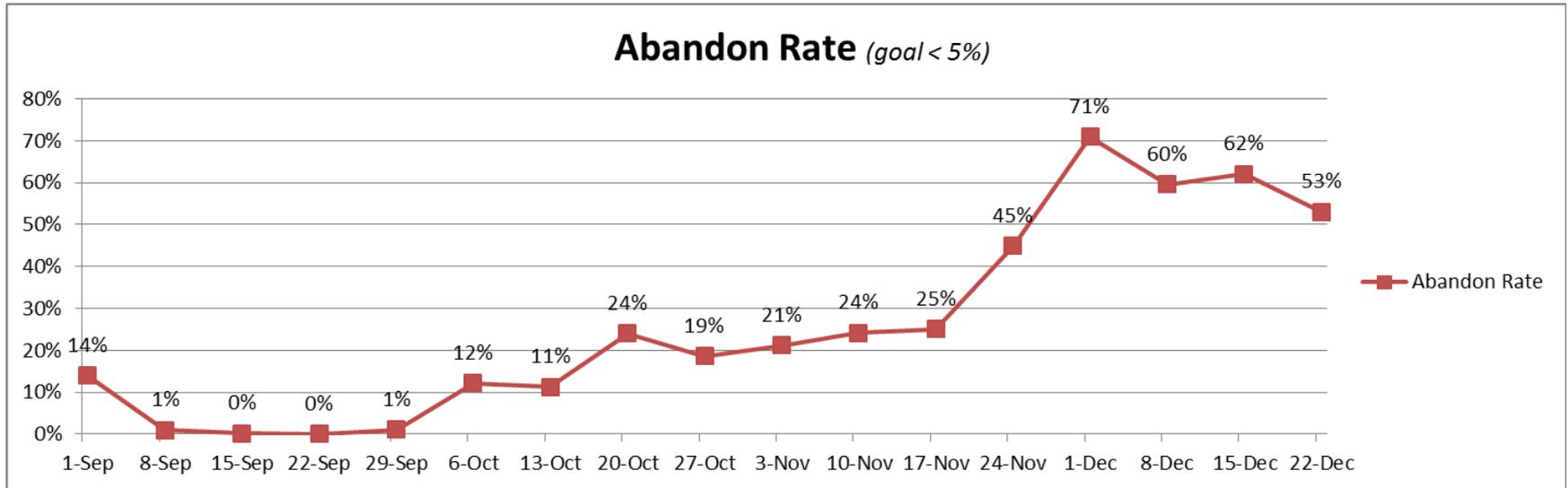
Time to Answer



Call Length & Wait Time



Abandon Rate



Summary of Challenges

- High call volumes with long call durations
- System limitations and workarounds
- New staff required to absorb complex content, working with current Green Mountain Care and Vermont Health Connect
- High staff turnover, recruitment challenges

Action Plan

- Transition from broad training (all staff able to handle all calls) to specialized skill sets
- Redesign IVR to optimize call flow
- Recast staff requirements based on current data and updated projections
 - Spring 2013 projections of 70 staff required → revised projection of 160 CSRs

January staffing plan

- Leverage existing Maximus call center in Chicago while continuing to recruit in Vermont
- Initial training of 44 staff in Chicago underway, with second group of 30 to start next week
- Chicago group to focus on dedicated tasks, including telephone applications, plan selection, plan/policy confirmation